State Affairs

The Impact of Medicare Rx on the States

An Analytical Framework

BACKGROUND PAPER

This paper was prepared at State Affairs' request by the Health Strategies Consultancy of Washington, D.C. It provides an analytical framework for assessing how the new Medicare drug legislation affects different state governments and state Medicare populations. Because of the complexity and variability in the Medicaid program, each state's unique characteristics will interact differently with the new Part D benefit. This framework will serve as a tool to navigate these complexities and help determine how each state and its residents are affected by the legislation. Health Strategies Consultancy is working with State Affairs to develop detailed qualitative and quantitative analyses, based on this framework, for each state. These analyses will be available in the spring.

The paper is divided into five sections:

I. Executive Summary

II. Key Provisions for States and Low-Income Beneficiaries: *Provides brief summaries of key provisions in the new legislation that are of most interest to states. These provisions include the low-income subsidies, responsibilities of states, and guidelines about using Medicaid funds for low-income Medicare beneficiaries.*

III. Analysis of the Drug Benefit: *Discusses the state-specific factors that can indicate whether the new benefit has an overall positive, neutral, or negative impact on governments and beneficiaries on a state-by-state basis. Sections include: (1) general Medicaid population and spending data; (2) eligibility level; (3) a state's history of drug cost containment strategies; (4)the presence of a state Rx assistance program or Pharmacy Plus waive; and (5) state responsibilities and options.*

IV. Conclusion

AARP

I. EXECUTIVE SUMMARY

The Medicare Modernization Act (MMA) will have fundamental effects on state Medicaid programs from both a fiscal and administrative perspective. Many of the changes will be focused on those Medicaid beneficiaries who are dually eligible for Medicare ("dual eligibles" or "duals")—a group that consumes a significant proportion of drug costs on account of their demographics and morbidity.

The key provisions of the new drug benefit affecting states and low-income beneficiaries include the following:

- Dual eligibles will receive drugs through the Medicare drug benefit upon full implementation of the MMA in 2006.
- Beneficiaries under 150% of the Federal Poverty Level (fpl) will receive low-income subsidies for their prescription drug costs.
- Dual eligibles get subsidy available to those under <135% fpl.
- Dual eligibles in nursing homes pay no cost sharing.
- States can use State-only funds to improve the benefit for low-income people (e.g., to "wrap around" the coverage lapse and other beneficiary co-payments). They cannot use Medicaid funds for this purpose.
- States continue to pay a decreasing portion of costs for duals' coverage through a mechanism referred to as the "clawback" formula.

Below are the major categories of factors that will determine the impact of the Medicare drug benefit on a state and beneficiaries within a state:

General Medicaid Population and Spending Data: The relative share of dual-eligible spending within a state's overall Medicaid budget provides a general indication of how important the new drug benefit is from a potential savings and cost perspective. The relative size of, and prescription drug spending data associated with, the duals population also generally can correlate to the leverage policymakers have had (and thus will lose in 2006) to negotiate discounts in Medicaid through Prescription Drug Lists (PDLs). It will be important to keep these general characteristics in mind when assessing how important the impacts of the factors in the other sections will be to the state.

Eligibility Data: Current Medicaid eligibility data can show the number of low-income residents who will benefit from the new federal coverage in 2006,

and also the number of beneficiaries whose current benefits will shift from Medicaid benefit designs to those adopted by Part D plans. In states with high Medicaid eligibility, or with a Pharmacy Plus waiver or state Rx assistance program, a relatively smaller number of new individuals will receive new drug coverage. More new people will be covered in states with low Medicaid eligibility levels. From the states' perspective, the more individuals currently covered translates into greater fiscal relief under the new law. This is particularly true in states that have covered beneficiaries under Pharmacy Plus or a state Rx assistance program (versus Medicaid eligibility expansions), because those beneficiaries are not part of the "clawback" formula.

Rx Cost Containment History/Pharmacy Plus/State Rx Assistance Programs: A state's current cost-containment efforts will directly impact whether low-income beneficiaries receive a more or less generous benefit in 2006. For example, if states had more restrictive cost-containment policies, like hard quantity limits or high co-pays, beneficiaries may now receive a better benefit under Medicare. States' perspectives will also vary based on current expansion efforts and benefit design decisions. If the state has relied heavily on a PDL as a way to control spending, the Medicaid program may face increased costs due to lost purchasing leverage related to the duals.

State Responsibilities and State Options: States face many decisions in preparation for the 2006 implementation of the new Medicare drug benefit (e.g., whether to use their state-only dollars to provide wrap-around coverage for cost sharing and drugs that Medicare does not provide). States also face significant administrative costs associated with the task of enrolling beneficiaries into new Part D plans.

This framework is a first step in helping states determine how to look at MMA, and helping beneficiary advocates figure out how to apply their energy. In general, most states will derive some financial benefit from this legislation, and low-income beneficiaries who are not covered by Medicaid or another state program will benefit significantly from this legislation. However, the degree to which both the states and beneficiaries are better off depends on the set of factors that are explained in the framework.

II. KEY PROVISIONS FOR STATES AND LOW-INCOME BENEFICIARIES

The following is a summary of the major provisions in the new Medicare drug benefit legislation that will affect states and their residents, in particular their dual eligible, state Rx assistance program, and other low-income populations.

Subsidies for Low-Income Beneficiaries and State Assistance Programs

All dually eligible beneficiaries qualify for the subsidies available to beneficiaries under 135% fpl, regardless of income and assets. The legislation provides significant subsidies to low-income beneficiaries under 150% fpl, with small cost-sharing obligations. Additionally, dually eligible nursing home residents pay no cost sharing for drugs.

The subsidies are:

- Under 100% fpl and a dual eligible—Subsidy for 100% of Part D premium, no deductible, cost sharing for all costs up to the catastrophic spending level of $1 for generic or preferred multi-source drugs and $3 for brand name or non-preferred drugs. Cost sharing is eliminated after the catastrophic spending level limit is reached.
- Between 100% and 135% fpl and those under 100% fpl who are not duals—Subsidy for 100% of Part D premium, no deductible, cost sharing of $2 for generic or preferred multi-source drugs and $5 for brand name or non-preferred up to the catastrophic spending level.
- Between 135%-150% fpl—Sliding-scale subsidy for Part D premium, $50 deductible, 15% cost sharing for all costs up to the catastrophic spending level and cost sharing for all costs above the catastrophic spending level of $2 for generic or preferred multi-source drugs and $5 for brand name or non-preferred drugs.
- Deductible and cost-sharing amounts are increased each year beginning in 2007 by the annual percentage increase in per capita beneficiary expenditures for Part D covered drugs (the average may be 8-10% annually), except for the $1 and $3 cost sharing, which will increase by the percentage increase in CPI (1-3% annually, in recent years).

An asset test will be applied to determine eligibility for Part D subsidies, except in cases where a Part D enrollee is a full dual eligible (no asset test applies in those cases). The asset test will be:

- Part D enrollees with income up to 135% fpl—Asset test is $6000 single/$9000 couple (same as three-times current law for SSI eligibility) in 2006, increased in subsequent years by CPI.

- Part D enrollees with incomes below 150% fpl who do not qualify for the <135% fpl subsidy—Asset test is $10,000 single/$20,000 couple, increased in subsequent years by CPI.

State Maintenance of Effort for Dual-Eligible Drug Coverage

Although benefit responsibility for the dual eligibles shifts to Medicare, states are required to continue to pay a portion of the drug costs for this population. The legislation establishes a formula by which states' responsibility decreases from 90% of a state's share of duals' prescription drug spending in 2006 to 75% in 2014 based on FY2003 spending amounts for this population, increased over time in most years by the growth in Part D prescription drug costs. This is commonly referred to as the "clawback formula."

The formula stipulates that states will reimburse the federal government for duals' drug costs as follows:

(No. of duals) * (Duals' drug per capita costs [weighted] in 2003) * (1/12) * (SMAP) * (Drug Inflation) * (factor) = reimbursement

Number of duals: The number of people dually enrolled in both Medicare Part D and Medicaid in the state.

Duals' per capita drug costs in 2003: Weighted average of gross fee-for-service and estimated managed care prescription drug costs under capitated plans for duals in 2003.

1/12: Included to convert yearly per capita to a monthly per capita.

SMAP: The opposite of FMAP, it is the state's share of Medicaid costs. I.e., if the FMAP is 57%, the federal government pays 57 cents of every $1 in Medicaid costs; the SMAP in this case is 43%.

Drug Inflation: In 2006, the inflation factor is the three-year per capita average growth rate in prescription drug costs nationally. In subsequent years, the inflation factor will be the annual per capita growth rate in Part D.

Factor: The factor determines the percent of these costs the states are required to pay. The factor decreases each year in accordance with the following table:

2006	2007	2008	2009	2010	2011	2012	2013	2014	….
90%	88 1/3%	86 2/3%	85%	83 1/3%	81 2/3%	80%	78 1/3%	76 2/3%	75%

Wrap-Around Policies

Cost Sharing: The legislation does not allow states to use Medicaid funds to wrap around cost sharing in the new Part D benefit. States can use state-only funds to finance such a program.

Prescription Drugs: States, through the Medicaid program, are permitted to cover drugs not on the Medicare formulary, provided that the Medicare formulary does not include any drugs from the same therapeutic class. There is no direct prohibition of states wrapping around formularies with drugs or cost sharing using state-only funds, however, some have expressed concerns that this will interfere with Part D plans' ability to design cost-effective policies. This is a question that will probably only be resolved when the Secretary issues regulations.

Discount Card

The discount card program is engineered to provide relief to low-income seniors between the time of the legislation's passage and Part D implementation. Medicaid and Medicaid 1115 waiver (e.g., Pharmacy Plus) beneficiaries are not eligible to receive the discount card, which CMS expects to provide a discount of 10-15%. Beneficiaries enrolled in state-only funded Rx assistance programs are eligible for both the discount and the $600 discount card subsidy provided to low-income beneficiaries.

Calculation of Best Price

Medicare pricing for the discount card and Part D will not be included in the calculation of Medicaid best price. Discounted inpatient drug prices charged to certain public safety net hospitals will now be excluded from the best price calculation as well.

Administrative Responsibilities

States are required to perform eligibility determinations and to enroll people in the Part D low-income subsidy programs. States will be reimbursed at Medicaid administrative costs rates. The Social Security Administration (SSA) offices are also tasked with these two functions. There are still many questions about how dual eligibles will be seamlessly enrolled in Part D and the exact administrative and cost burden this will pose for states.

III. ANALYSIS OF THE DRUG BENEFIT

Several different state characteristics will inform a state's thinking on the Medicare drug legislation and determine whether a beneficiary is better off after the passage of the bill. The following analysis will aid in a state-by-state assessment of the legislation's impact. In each of these sections, we describe several important factors that will determine how states and beneficiaries fare when the Part D benefit goes into effect.

Throughout this analysis it is essential to remember that each factor is only part of the equation of how a state and its residents benefit from the drug legislation. One factor may reduce the benefit for a state, but the next element could be positive. In some cases, one factor may have both negative and positive implications for a state. Finally, the degree to which a particular factor impacts a state will vary.

1. General Medicaid Population and Spending

With the passage of the Medicare drug benefit, management and a larger share of the prescription drug costs for the dual-eligible population will be moving from Medicaid to the Medicare program. While this change impacts every state, the magnitude of the change to a state's financial situation will depend on several elements discussed below.

Factor One: The number of duals relative to the Medicaid aged/disabled population and to the overall Medicaid population.

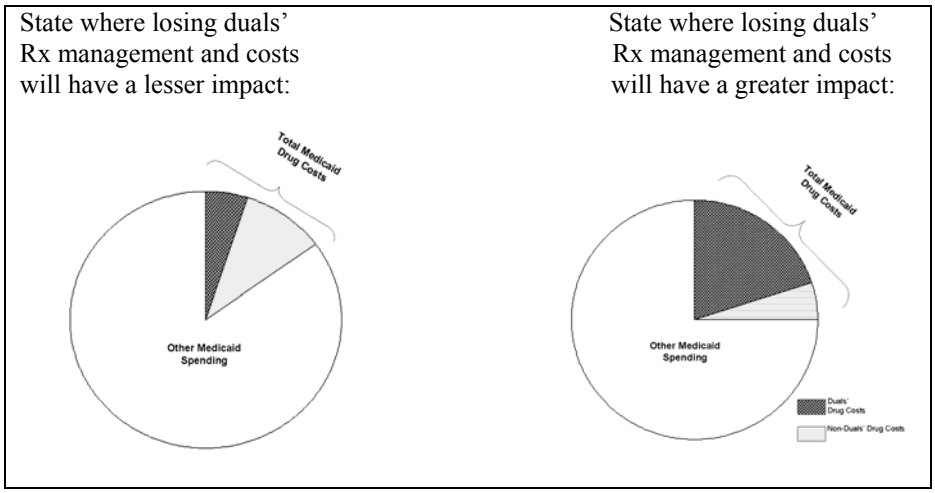
Factor Two: The percentage of duals' drug costs relative to total Medicaid drug expenditures.

Factor Three: The percentage of total Medicaid drug expenditures relative to total Medicaid spending.

The magnitude of the state's overall drug budget and the size of and spending associated with the dual-eligible population may provide some indication of how focused a given state's policymakers are on the new legislation. These three factors, taken together, are important for two reasons:

- *Impact of size and spending on relative importance of federal fiscal relief and future clawback payments.* States with larger dual populations and a larger share of drug spending associated with duals will experience greater fiscal relief relative to the Medicaid prescription drug budget when the Part D benefit goes into effect. Further, states with such characteristics *and* high levels of prescription drug spending relative to the total Medicaid program will experience greater relief in their overall Medicaid budgets.

- *Impact of size and spending on leverage in future price negotiations.* At least thirty states have implemented or have obtained the authority to implement a preferred drug list (PDL). PDLs are lists of preferred medications that in most states beneficiaries may receive without first obtaining prior authorization. Approximately fifteen of these states have sought supplemental rebates from drug manufacturers in association with these PDLs. Manufacturers agree to provide additional rebates in part because of the shift in market share states can promise. If duals constitute a large proportion of a state's drug cost—and thus are an important part of the share shift equation conducted by manufacturers—states are likely to lose significant negotiating leverage as the management of duals' spending shifts to the Medicare program. If drug costs are a relatively high percentage of a state's total Medicaid spending, this lost leverage will be even more significant.



Factor Four: The percentage of duals and all Medicaid beneficiaries in managed care.

Drug costs for people in managed care generally are included in capitated payments and thus are the responsibility of managed care plans. State mechanisms to directly control drug costs (e.g., PDLs, quantity limits, etc.) to date have only applied to the fee-for-service population. Again, the higher the percentage of duals in the state's fee-for-service program, the more dependent the state is likely to be on this population when negotiating PDLs and implementing other cost-containment tools intended to reduce overall Medicaid drug spending. The loss of the duals to Medicare management will force states to explore other cost-containment options that can be brought to bear on the remaining fee-for-service and also the state's managed care populations.

These general factors about a state's Medicaid population characteristics and spending demonstrate that the picture for states is complicated. On the one hand, the more duals they have, the more they benefit financially from the shift of additional costs to Medicare. On the other hand, states also have to maintain spending on this population—which can be significant in states with large duals populations—as part of the "clawback" formula, while they do not have any control over how duals' drug costs are managed. It will be important to keep these general characteristics in mind when assessing how important the impacts of the factors that follow will be to the state.

2. Low-Income Beneficiary Eligibility Levels

An assessment of current Medicaid and related program eligibility levels can provide insight into the number of state residents who now will have new access to subsidized drug coverage. While some of these individuals may have drug coverage through retiree health plans or Medigap plans, low-income beneficiaries generally are less likely to have drug coverage than the broader Medicare population.

Factor One: Eligibility Levels for Medicaid (including coverage levels for those enrolled under 1115 and 1915 waivers and the medically needy/spend down categories), Pharmacy Plus waivers, and state Rx assistance programs.

Given the difficulty in obtaining detailed state-specific income data for Medicare beneficiaries, certain Medicaid eligibility information can help to assess the number of state residents who now will have drug coverage with a low-income subsidy. Assuming a large portion of these individuals currently lack drug coverage through a retiree health plan or Medigap plan, one could estimate the number of individuals receiving access to a new benefit.

Impact on States

Positive:

- Eligibility and the presence of non-Medicaid prescription drug assistance programs are important in that the number of duals is part of the "clawback" formula for states. Because the state does not have to continue to maintain a portion of the drug costs for beneficiaries above its Medicaid levels, the state benefits if it has low coverage levels for Medicaid and either has: (1) provided drug coverage through a non-Medicaid prescription drug assistance program or a Pharmacy Plus waiver or (2) not extended coverage levels at all.

Negative:

- States with Medicaid eligibility set above mandatory levels will pay more than they would if they only covered the elderly at federally

required levels (or through a non-Medicaid prescription drug assistance program or a Pharmacy Plus waiver).

The only element in the "clawback" formula that states have any ability to control is the number of duals. This may mean that states reduce coverage in order to avoid paying more. However, since states would have to stop providing all services to duals (e.g., long term care), political pressure may prevent them from doing so.

Impact on Beneficiaries

Determining the coverage levels in a state also provides an indication of the number of low-income beneficiaries that will experience different coverage under MMA versus those who will receive new coverage.

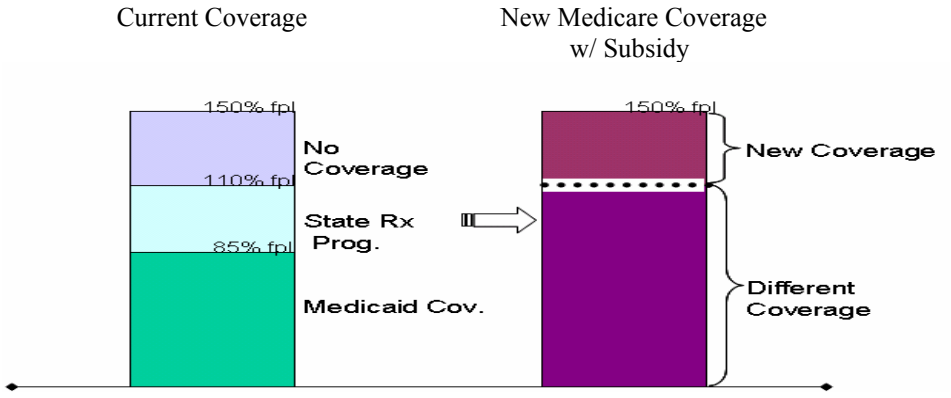
Positive

- If the state's Medicaid eligibility is at mandatory levels, and no Pharmacy Plus or other senior drug assistance program is in place, more low-income beneficiaries will benefit because they lacked drug assistance before the passage of MMA.

Positive, Negative, or Neutral

- If the state currently has high levels of drug coverage, beneficiaries' coverage will change under MMA. In such cases, the impact on beneficiaries will depend on factors described in the next section, on cost-containment.

Example: Residents of State X with incomes of 85% fpl are eligible for Medicaid and the state has a Rx assistance program up to 110% fpl. This means that elderly residents with between 110% and 150% fpl will now have access to a low-income subsidy and government sponsored drug benefit when they likely did not have access to such coverage before.



Factor Two: Whether a state has a Medicaid asset test.

Beneficiaries who are not dual eligible must meet an asset test for the low-income subsidy, and many states have asset tests for their Medicaid programs.

Impact on States

Positive:

- If the state has a stricter asset than the federal asset test, many people who fall in the dual eligibility income levels were disqualified from Medicaid – they will now be eligible for the subsidy under MMA. The state is better off because their residents gain coverage but are not included as part of the "clawback" formula.

Negative:

- If states have a less restrictive asset test, the duals are deemed eligible for the low-income subsidy and the state is still responsible for a portion of the duals' drug costs.

Impact on Beneficiaries

Positive:

- If the state has a stricter asset test, Medicare-only low-income beneficiaries are better off because they are now eligible for drug coverage with a subsidy, whereas they were not eligible for drug coverage under Medicaid previously. These beneficiaries should be counted when estimating the number of people with new coverage.
- If the state has a less restrictive asset test, the duals benefit because they are "grandfathered in" to the low-income subsidy available to those under 135% fpl.

Factor Three: The number of Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualified Individuals (QIs) in the state.[1]

These low-income beneficiaries receive subsidies for Medicare cost sharing but most likely lack drug coverage currently. As the eligibility levels for these groups is up to 135% fpl and the asset tests for these programs are stricter than for the new drug benefit subsidies,[2] these beneficiaries will be eligible for the low-income subsidy. The number of beneficiaries in these categories is a good estimate of the number of individuals who will enroll in the low-income subsidy. Note: Less than three-fourths of Medicare beneficiaries who are eligible for the QMB/SLMB/QI programs are actually enrolled, so this

[1] States and the federal government pay for Medicare cost sharing on behalf of Medicare beneficiaries enrolled in the QMB, SLMB, QI programs.

[2] If a state has used its own funds to expand eligibility for these groups above 150% fpl, these beneficiaries may not be eligible for the drug benefit.

number alone will likely understate the number of beneficiaries who could benefit from the new Part D coverage.[3]

3. Current State Rx Cost-Containment Strategies

The different policies states have used to structure their Medicaid drug benefit will also play a role in determining how Medicare Part D impacts states and beneficiaries. States have used a variety of tools to help lower and contain Medicaid fee-for-service pharmacy costs, which may impact the state's "clawback" formula and the extent to which the drug benefit will differ for dual eligibles shifting from Medicaid to Part D benefit plans. The following section defines the three most common strategies states have pursued, and assesses how Medicare Part D may impact the state and its beneficiaries due to presence or absence of each cost-containment tool.

Factor One: Whether a state has implemented a PDL.

PDLs are lists of preferred medications that in most states beneficiaries may receive without first obtaining prior authorization. More than 30 states have implemented or plan to implement a PDL program and no two PDL programs look exactly alike—differing in processes developed, scope of the list, number of beneficiaries affected, and strategies by which lists are enforced among physicians (e.g., prior authorization). Many states have used PDLs to obtain supplemental rebates from drug manufacturers in exchange for placing products on the preferred list.

Impact on States

Positive:

- If the state has implemented a PDL program prior to 2003 and as a result has been able to lower its drug costs, then the state's drug per capita costs for duals, a variable in the state's "clawback" formula, will be smaller. The smaller variable means that the state will have to reimburse the federal government less for duals' drug costs then they would have had savings from a PDL not been incorporated into their 2003 figures. Non-PDL states missed the opportunity to lower their mandated contribution over time.

Negative:

- When Medicare begins managing the prescription drug benefit for all dual eligibles, many Medicaid PDL states will likely lose a large volume of the fee-for-service beneficiaries affected by the policy. This loss of volume will potentially make it difficult for states to negotiate supplemental

[3] This estimate is approximate, and enrollment for these programs varies from state to state and by program.

rebates with drug manufacturers going forward, forcing states to find alternative prescription drug cost-containment mechanisms.

- If by 2006 a PDL program is able to lower a state's prescription drug spending growth rate below the three year average of the national Rx costs growth rate, or in subsequent years the annual growth rate of Part D, then the state may be paying for drug costs that grow at a higher rate then they would have under the state's management.

Impact on Beneficiaries

Positive:

- Beneficiaries in a state with very restrictive Medicaid PDLs may face fewer prescription drug restrictions under Medicare Part D, depending on the formularies these new plans put into place. CMS implementing regulations may provide additional insight into the types of formularies Part D plans are permitted to apply to dual eligible populations.

Negative:

- Beneficiaries in a state with no Medicaid PDL will most likely face more restrictions for access to drugs under the new Medicare benefit, given the likelihood of Part D formularies.
- Even if beneficiaries reside in a state with a Medicaid PDL, they could face more restrictions if the Medicare plan's formulary is more restrictive than the state's current program. (E.g., Oregon's PDL, a voluntary list of drug recommendations in 9 classes, will most likely be less restrictive than what Oregon's duals will face in the new Medicare benefit.)

Factor Two: Whether beneficiaries pay copayments.

Some states ask beneficiaries to pay a small copayment amount at the pharmacy for drugs. Many states charge a slightly higher copay for brand name drugs versus generics to encourage beneficiaries to choose the cheaper drug. However, states are limited with this strategy since they can only charge a minimal copay up to $3 and pharmacists must dispense a prescribed drug without a copay if the beneficiary claims to not be able to afford it (i.e., the copays are not enforceable in the Medicaid program).

Impact on States

Negative:

- States, especially those with state pharmacy assistance programs in place, may be politically pressured to use state-only dollars to provide wrap-around coverage for new Medicare cost-sharing requirements. In addition, the administrative challenge of coordinating payments for the cost-sharing requirements with the Medicare program could be difficult and costly for states.

Impact on Beneficiaries

Negative:

- For many beneficiaries, the new copay requirements in the Medicare benefit will be higher than they are currently in the state's Medicaid program. (E.g., 11 states currently have no Medicaid copay requirements and 13 states' Medicaid co-pays are below Medicare's levels.)
- While there are some states that have copay requirements equal to or higher than the new Medicare requirements, the current law does not require Medicaid beneficiaries to pay them to obtain the drug. Medicare may mandate that all beneficiaries pay the required copays, regardless of ability or income.
- Medicare cost-sharing increases automatically by CPI each year, whereas Medicaid cost sharing is stable, unless changed by the legislature or the Medicaid agency.

Positive:

- If 1115 Pharmacy Plus waiver (or 1115 drug-only waiver) beneficiaries are eligible for the new Medicare benefit, then, in some states, copayments may significantly decrease for this population. (E.g., co-pays in the Maryland 1115 waiver program are 65% of the drug's cost for some beneficiaries.)

Factor Three: Whether a state imposes quantity limits.

Another strategy used to control Medicaid prescription drug costs is placing a quantity limitation on the drug benefit. There are two major types of quantity limits, "hard" and "soft." Hard limits place caps on the amount of benefits available to recipients (e.g., limits on the number of Rx per beneficiary per month or dollar limits on Rx payments per beneficiary) and ultimately limit access to prescribed drugs. Soft limits, such as limits on the amount of medicine that may be dispensed per prescription or number of refills, are intended to promote economy in dispensing or guard against fraud. Most states use prior authorization policies for beneficiaries that need to exceed any of the defined quantity limits.

Impact on Beneficiaries

Positive:

- Hard quantity limits will most likely not be a cost-containment tool used by private Medicare prescription drug plans. Therefore, dual eligibles living in a state with hard quantity limits will be less restricted when covered under the new Medicare prescription drug benefit.

Potential Changes in State Cost-Containment Strategies

The new Medicare drug benefit may alter states' strategies to reduce Medicaid fee-for-service drug costs. Due to the loss of the dual eligibles and thus beneficiary volume, the most significant impact will relate to states' ability to obtain PDL supplemental rebates from drug manufacturers going forward. States may shift to some of the following alternative drug cost containment strategies:

- *Pursue Bulk Purchasing Pools:* States may try to increase beneficiary volume to leverage larger discounts from manufacturers by pooling their Medicaid beneficiaries with other states or with other state agencies. Multi-state purchasing pools may gain greater attention, such as the recent initiative led by First Health with Michigan, South Carolina, and Vermont. Other states may concentrate on intrastate drug purchasing pools, which combine Medicaid beneficiaries with populations in other state agencies (e.g. state employees).
- *Carve Out Rx Benefit:* Another tactic states might use to increase beneficiary volume is to carve out the prescription drug benefit from all Medicaid managed care organizations in the state. This would force all Medicaid beneficiaries to receive prescription drugs through the Medicaid fee-for-service program under one PDL. Tennessee is an example of a state that has already pursued this strategy by creating a single PDL and carving out the drug benefit for beneficiaries enrolled in the state's seven TennCare MCO plans.
- *Create More Restrictive PDLs:* Fiscal pressures may drive states to expand the scope of their PDLs to address more drug classes. This may include adding restrictions to some of the more expensive drug classes for vulnerable patients that have generally been exempted from PDL programs (e.g., atypical antipsychotics and other categories of mental health drugs). States may also re-address PDL selections and begin to limit the number of preferred drugs per class to increase market share for the selected drugs.
- *Cut Pharmacy Reimbursement Rates:* States may return to cutting pharmacy reimbursement rates to account for lost savings from PDL programs. Despite pharmacies' opposition, historically these cuts have amounted to immediate savings for states. Medicaid may also eventually feel pressure to match the reimbursement cuts Medicare is making for its Part B drugs.

4. State Rx Assistance and Pharmacy Plus/1115 Drug-Only Waiver Programs

Factor: Whether a state expanded coverage through a state Rx assistance or Pharmacy Plus program.

About half the states have provided drug coverage to low-income beneficiaries above Medicaid coverage levels. These beneficiaries are not receiving comprehensive health coverage but receive drug-only assistance under a Pharmacy Plus waiver or a state-funded Rx assistance program.

Impact on States

Positive:

- Unlike dually eligible Medicaid beneficiaries, beneficiaries covered under a Pharmacy Plus waiver or a state assistance program are not counted in the states' "clawback" formula. Thus, the states have no requirement to contribute to the Part D cost of providing drugs for these individuals. States with Rx assistance programs or Pharmacy Plus waivers will save money in drug benefit costs if these individuals enroll in Part D.

Negative:

- States cannot provide drug coverage to duals enrolled in Medicaid, but there is nothing prohibiting the state from continuing to provide drug coverage in a state Rx assistance program. Some Medicare beneficiaries enrolled in the state program may wish to stay in that program rather than enroll in the Part D program. States may face pressure to continue to allow Part D eligible beneficiaries to participate in the state program.

Impact on Beneficiaries

The impact on beneficiaries covered by state Rx assistance or Pharmacy Plus programs is very similar to the impact on duals described in the above section on cost containment. Like duals, these are individuals who currently have drug coverage. States have much greater leeway in designing their drug benefit than they do under the Medicaid program.

Positive:

- In some states, the state-sponsored drug benefit may be very limited, making the new coverage under Part D much more generous for beneficiaries.

Negative:

- In states with a more generous package, the benefits under Part D will be comparable to or worse than the benefits under the state Rx program.

5. Role of the States

States face both new responsibilities and new decisions in preparation for the 2006 implementation. States will still have to pay a portion of duals' drug costs, even though they are not administering the program, as well as costs to screen and enroll beneficiaries in the low-income subsidy programs. States will also need to decide whether to provide wrap-around drug costs and benefits. This section summarizes the responsibilities and options for the states.

State Responsibilities

REQUIREMENT	IMPACT
States are still required to pay most drug spending for duals. • Through the "clawback" formula, states continue to pay for drug spending. • Formula is based on their 2003 drug per capita costs. • Formula also increases by the growth in per capita drug costs under Medicare Part D.	*Positive:* • States that successfully contained costs in 2003 gain under the formula. • States whose drug cost growth is higher than the national average also stand to gain. *Negative:* • States have no control over changes in drug costs and thus no control over the amount of funding they contribute except the number of duals. • Setting aside the fact that the federal government is assuming a larger share of the costs, states who imposed cost-containment strategies that lowered the growth in drug costs may pay for drug costs that grow at a higher rate than their current growth rate.
States are required to determine whether Medicare beneficiaries are eligible for subsidies. Beneficiaries can enroll in the Medicare subsidy program at the Medicaid office. SSA also has eligibility determination and enrollment responsibilities.	*Negative:* States will receive Medicaid administrative costs match for these activities. This is a new expense for them, which reduces the savings that they see from the "clawback" formula.
The Secretary is instructed to coordinate low-income subsidies with states' pharmacy assistance programs.	Regulations will need to address how states will operate their programs in conjunction with the Medicare structure.

State Options

Factor One: Whether a state decides to provide wrap-around cost sharing.

In states with low copays for drug coverage through Medicaid, Pharmacy Plus, and/or a state Rx assistance program, beneficiaries will be paying more under the Medicare system and states may want to pay the additional cost sharing for duals (or any other residents whose drug coverage was less expensive).

Example: Cost sharing for a Dual Beneficiary in New Hampshire

	Generic	Brand Name
Medicaid cost sharing:	$0.50	$1
Medicare cost sharing:	$1	$3
Potential wrap-around:	$0.50	$2

Impact on States

Negative:

- Since no federal funds from the Medicaid/SCHIP programs can be used for wrapping around Medicaid cost sharing, states will have to use their own funds for this purpose. Even though wrapping around is an option, states may face political pressure to provide wrap-around cost sharing or benefits, which represents a new expense for the state not accounted for in CBO scoring.
- Wrap-around policies in other contexts of the Medicaid program (e.g., wrapping around employer-sponsored insurance) is a time-consuming and complicated process. Since these copays will be relatively small per individual, the administrative costs might even equal or outweigh the cost of the benefit.

Impact on Beneficiaries

Positive:

- If the state chooses to provide wrap-around cost sharing, beneficiaries are essentially "held harmless" from any increases in cost sharing. Also, beneficiaries may gain if the Part D benefit is more generous and the state ensures that the beneficiaries pay the lower cost sharing.

The exact mechanism of paying for beneficiaries' cost sharing for both the Part D subsidy and state wrap-around is unclear. To clarify all of these

issues, the Secretary is required to issue regulations that provide guidance for coordinating state programs with Part D plans.

Factor Two: Whether a state provides wrap-around prescription drugs.

The Medicaid program is permitted to wrap around classes of drugs that are not included in a Part D plan.

> Example: A Part D plan operating in Oregon chooses not to cover over–the-counter (OTC) medications, which is a voluntary class for Medicare plans. Currently, Oregon covers OTC Prilosec under the Medicaid program. Oregon Medicaid can provide OTC Prilosec to the dual if the state chooses to do so.

However, a state cannot use Medicaid to wrap around within a class. For instance, a Part D plan covers drugs to lower cholesterol, but Lipitor is not covered by the plan's formulary. Even if Medicaid covers Lipitor, the dual beneficiary would not be able to receive the drug through Medicaid.

In the example above, it is unclear whether the state would be able to provide Lipitor using state-only funds. While the law generally allows states to provide wrap-around coverage, questions have been raised about whether doing so would interfere with the cost-containment strategies of the Part D plans. This is an issue that will probably have to be addressed by through the federal regulatory process.

Impact on States

Negative:

- States will face administrative and benefit costs if they decide to provide wrap-around benefits.
- If states do not provide wrap-around benefits, they will likely anger advocacy organizations.

Impact on Beneficiaries

Positive:

- If a state chooses to provide wrap-around benefits, beneficiaries will have access to the greater benefit in every class. Where the state benefit is more generous than Part D, the stay pays; where the Part D is more generous, Medicare pays.

IV. CONCLUSION

As this analysis illustrates, the new Medicare law's impact on states and low-income beneficiaries depends on multiple characteristics of a state's current prescription drug benefit programs. In some instances, one factor may be a positive for a state, but a negative for beneficiaries, or vice versa.

Beneficiaries: The impact on low-income beneficiaries varies by the type of benefit they currently receive. Those low-income beneficiaries who lack drug coverage now benefit the most from the availability of new coverage. Those in states with generous coverage under Medicaid or a state assistance program will see a reduction in their benefits, unless the state chooses to fill in the gaps. Those in states with limited coverage now will likely be better off receiving coverage under the new benefit.

States: The impact on states varies by the structure of their current programs, in particular whether they chose historically to extend coverage to the elderly through Medicaid expansions or only provided drug coverage through a waiver or state Rx assistance program. How states chose to control drug spending will also dictate the new law's impact. All states will benefit financially to some degree by the federal government's assumption of a greater share of prescription drug costs. Whether that benefit outweighs the loss of revenue through supplemental rebates and the new administrative costs for eligibility determinations and wrapping around cost sharing will depend on choices states makes in the future, and how much they want to preserve the benefit that their duals population currently receives.

The biggest decision for the states is whether to provide wrap-around benefits and assume the administrative burden that goes along with providing that service. They need to decide whether it is important to them that low-income beneficiaries continue to receive the same level of benefits they do now. If a state chooses to provide wrap-around benefits up to current levels, then the impact on Medicaid, Pharmacy Plus, and state Rx assistance program beneficiaries will be either completely neutral or positive under the new legislation.

This framework describes the multiple factors that must be considered in order to determine how states and their low-income beneficiaries will be affected by the new legislation. The forthcoming qualitative and quantitative analyses will use state-specific information, in conjunction with the framework, to assess the impact of the new law on a state-by-state basis.

The Impact of Medicare Rx on the States

Health Strategies Consultancy, of Washington, D.C., provides strategic consulting, policy guidance, and research on health care issues.

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